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KANSAS HEALTH POLICY AUTHORITY

Agency Follow-up to Questions from the Joint Committee on Health Policy Oversight August 14th Hearing

November 20, 2008

1. **Identify the reasons why non-state groups are not joining the State Employee Health Benefit Plan (SEHBP)? What is the number of employees of a non-state group that have to participate and the amount the non-state employer has to contribute to join the state plan?**

   The agency has identified three primary reasons why non-state groups are not joining the SEHBP: the 70% participation rate requirement, the amount of required employer contribution, and the ability of groups to find less expensive health insurance products. The State Employee Health Plan has examined the participation requirement and is reluctant to reduce that requirement due to concern with adverse selection. Non-state employers are required to match the amount that the state as an employer contributes to employee health insurance, which is currently set at 95% of the total cost for an individual and 55% of the cost of a member with dependents. Non-state employers, however, are given an opportunity to get to that contribution level over a three year time period, which provides them with some time to reconfigure their budgets.

   In order for an employer to participate in the SEHBP, they must have 70% of their eligible employers take up the coverage. They pay a total of 101% of what active state employees pay. The employer must make the same contribution to an employee's premiums that the state makes for an active employee: 95% for a single member and 55% for a member plus dependents.

2. **What is the projected number of pregnant women who will be eligible to receive Medicaid services as a result of the expansion of income eligibility criteria?**

   The expansion of Medicaid to pregnant women with family incomes up to 200% federal poverty level would provide coverage to an estimated 1,280 women when fully phased-in.

3. **What are the components of affordable health insurance referenced in the KHPA Health Reform Recommendations presentation slide 19?**

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Affordable health insurance coverage refers to the amount of a family's income needed to pay for health insurance premiums and cost sharing in relationship to total family income. Some states have attempted to quantify affordability, such as Massachusetts at a specific percentage of family income but Kansas has no policy imperative to set an affordability standard at this time.

4. **What is the impact of the proposed increase in tobacco tax by tobacco product type?**

   Consultation with Department of Revenue analysts indicate that the tobacco products tax estimates data base does not allow detailed specificity in delineation between smokeless, roll-your-own tobacco, and cigars. Legislative work done by the department in 2007 provided estimates that within this particular category of products, 75% of the tobacco products tax is generated from smokeless tobacco and roll-your-own and cigars make up the remaining 25%.

5. **What is the comparison of the state's current reimbursement Medicare rates for allowable charges, showing the top 10-12 areas of over/under reimbursement levels?**

   An analysis of Kansas Medicaid data comparing Medicaid physician payment rates to Medicare rates for certain procedure codes indicates the service reimbursement categories nearest to the Medicare level of reimbursement are: individual psychotherapy (92.98%), prolonged physician service in the office (92.97%), extended physician service in the office (92.52%), office visit (92.52%), and office consultation for a new or established patient (87.89%). The service reimbursement categories that are the lowest in relationship to the Medicare level of reimbursement are: percutaneous scratch tests (47.61%), individual psychotherapy 90806 (50.92%), health and behavior intervention (58.56%), pharmacological management (58.82%), and initial patient consultation (68.98%).

6. **What is the comparison of the qualifications for Level 1, 2, and 3 medical homes and what is the fee for certification and how frequently is re-certification required?**

   Attached you will find the National Committee for Quality Assurance (NCQA) standards which have frequently been used as criteria for evaluating medical homes. The fee for certification is based upon the number of physicians in the practice, starting at $450 for a solo practitioner and going up to $2,700 for a 100 physician practice. Re-certification is required annually.